PRINTED: 09/24/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185410	A. BUILDING _____ B. WING _____	09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER'S BEND RETIREMENT COMMUNITY	300 BEECH ST. KUTTAWA, KY 42055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey and abbreviated survèys (KY #15197, KY #15241 and KY #15256) were conducted 09/14/10 through 09/16/10 to determine the facility's compliance with Federal regulations. The facility was found not to be in compliance with Federal regulations with deficiencies cited. The highest S/S was "D". KY #15197 was unsubstantiated with no deficiencies cited, KY #15241 was substantiated with no deficiencies cited and KY #15257 was substantiated with a deficiency cited.	F 000	The preparation of this Plan of Correction does not constitute admission or agreemen t by the provider of the truth or fact alleged or conclusions set forth in statement of deficiency. The Plan of Correction is prepared or executed solely because it is required by federal and state law F 160 Criteria #1 For residents #11 and #12 the funds have already been conveyed and the accounts have been closed. For resident #11 this was completed on 0701/2010. Resident #12's account was closed on 07/01/2010. Criteria #2: An audit of discharged resident's accounts for the last twelve months will be completed by the Buisness Office Manager to ensure that all residents with a personal fund deposited with the facility have been conveyed and a final accounting of funds has been provided to the appropriate party. If this has not been completed, a final accounting and conveyance will be completed for those appropriate residents. Criteria #3: The Buisness Manager will be trained by the Administrator on the policy and procedure for conveyance of funds, and the corresponding regulation.	
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to promptly convey resident personal funds to the individual administering the resident's estate upon the death of the resident, for two residents (#11 and #12) of the five accounts reviewed. Findings include: A review of Residents Accounts conducted, on 09/15/10, revealed Resident #11 expired on 02/28/10 and the account was not closed until 07/01/10. Resident #12 expired on 11/29/09 and the account was not closed until 07/01/10. An interview, on 09/16/10 at 10:45 AM, with the	F 160		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Dawn Jeeder Administrator 9/27/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 160	Continued From page 1 Business Office Manger revealed she had taken the position of Office Manager on 07/26/10 and could not explain why the accounts were not closed. An interview with the Administrator, on 09/16/10 at 11:00 AM, revealed she was unaware the accounts had not been closed.	F 160	Criteria #4 One time a month for three months, and then quarterly, the Bulsness Office Manager will review accounts of Those residents that have been Discharged/deceased to ensure That a final accounting of funds, And conveyance of funds has been completed within 30-days.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	F225 CNA #1 was terminated on 7/27/2010 due to the Investigation that the facility conducted regarding residents #3 and #13. LPN #1 was also Terminated on 7/28/2010. She was terminated due to not following policy and procedure for reporting abuse/neglect, and for falsifying documentation. Administrator also reported LPN#1 to the Kentucky Board of Nursing In relation to her performance regarding this incident. CNA #2 was provided corrective action and suspended for two days due to not immediately reporting. A psychosocial Assessment was Completed on 7/27/10 by Sharon Wight, RN, BC. for resident #13. Psychosocial assessment was also completed for Resident #3 on 7/27/2010 by Sharon Wight, RN, BC.	Criteria #5 10/20/2010

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F 225	Continued From page 2 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure all alleged violations involving mistreatment, neglect or abuse were reported immediately to the Administrator. The facility also failed to prevent further potential abuse while the investigation was in progress, related to two residents (#3 and #13), in the selected sample of 10. Resident #3 alleged CNA #1 twisted his/her wrist during incontinent care. CNA #2 alleged CNA #1 was verbally and emotionally abusive to Resident #13. Neither incident was immediately reported to the Administrator and CNA #1 was allowed to continue working. Findings include: 1. Resident #3 was originally admitted to the facility on 02/01/08 and readmitted on 09/08/10 with diagnoses to include Chronic Back Pain, Osteoporosis and Alzheimer's Dementia. The quarterly Minimum Data Set (MDS) dated 06/03/10, revealed the resident was moderately impaired cognitively and was totally dependent on the assistance of two staff members for all care and was frequently incontinent of bowel and bladder. An observation and interview with Resident #3 on 09/16/10 at 1:55 PM, revealed the resident	F 225	Criteria #2 On 7/28/2010 Danielle Newell, Social Services Director, interviewed all of River's Bend Nursing Facility and Personal Care residents to to identify any other residents that had the potential to be affected by the same deficient practice. At this time no other residents had any complaints about staff or care regarding abuse/ neglect and CNA #1. Criteria #3 An inservice was held on 8/4/2010 by Randa Ramsey, Ombudsman, and Dawn Tedder, Administrator. The topic was abuse and neglect/staff burnout. The abuse/neglect policy was also revised by the Administrator as a result to this investiga tion. It was addended to state the following: The staff reporting abuse/neglect, and their supervisor should immediately report the abuse/neglect together to the Administrator or appropriate person on call. Training was provided by the Administrator on the revised Policy on 8/4/2010. Staff also signed a new acknowledgement of the abuse/neglect policy. Upon hire the revised abuse/neglect policy will be reviewed with staff by the Assistant Administrator/HR rep., and it will be reviewed in the orientation class that is provided to new employees. A copy of the policy was also provided to OIG surveyors at the time of visit.	

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F 225	Continued From page 3 was alert, lying in bed and slightly short of breath after incontinent care. The resident did not remember CNA #1 and denied anyone ever saying or doing anything harmful to him/her. The resident's right wrist showed no evidence of redness, edema or bruising. An interview on 09/15/10 at 2:07 PM with CNA #2, revealed CNA #1 and CNA #2 were working the third shift together on 07/23/10 at 11:50 PM. While providing incontinent care to Resident #3, the resident attempted to scratch his/her buttocks. CNA #1 grabbed the resident's right wrist and stated, "You are going to get your hand full of shit" The resident responded, "Talk nice to me." CNA #1 told the resident that he was being as nice as he could. He was pulling the resident's arm up against the resident's side. He then grabbed the resident by the right wrist and applied pressure. CNA #2 was able to see an indention on the resident's skin and the resident was grimacing his/her face. The resident asked CNA #1 to stop twisting his/her arm. The CNA denied he was twisting the resident's arm and replied, "Today is not your lucky day, but tomorrow may be." As the CNAs left the room, CNA #1 asked CNA #2 if she was going to tell anyone about the incident. She reported the incident to Licensed Practical Nurse (LPN) #1 approximately 10 minutes after the incident, on 07/24/10 at 12:00 AM. However, the LPN stated she was not going to call anyone about the incident "now". CNA #1 continued to work with residents. CNA #2 was present when at approximately 2:00 AM, on the same shift, the Assistant Director of Nurses (ADON) called the facility and talked with LPN #1. The LPN did not make the ADON aware of the incident during this phone call. At 3:30 AM, CNA #2 called the ADON and reported the incident.	F 225	Criteria #4 The abuse/neglect policy will be inserviced by the Administrator one time a month for three months and then quarterly after this. Any abuse/neglect allegations reported will be reviewed by the Administrator to ensure that they were reported immediately according to policy and procedure. If they are not reported immediately the staff resposnible will receive corrective action as indicated per disciplinary policy, which may include termination.	Criteria #5 10/20/2010

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F 225	Continued From page 4 The CNA stated soon after she called the ADON, the LPN came to the break room and asked her why she called the ADON. After this, the LPN called the Administrator and reported the incident. CNA #2 stated CNA #1 was instructed to clock out between 4:00 AM and 4:30 AM. An interview on 09/15/10 at 3:00 PM with the ADON, revealed she was on-call the week-end of 07/23-24/10. She was first made aware of the incident "in the wee hours of the morning on 07/24/10" when CNA #2 called her and inquired if LPN #1 had reported the incident to her. CNA #2 then reported that CNA #2 had verbally and physically abused Resident #3 and that she reported the abuse to LPN #1, but she did not think the LPN reported the abuse to her (ADON). The ADON revealed when she finished talking to CNA #2, she called LPN #1, who stated, "I did not feel it was abuse." When the ADON called back, LPN #1 was talking to the Administrator. An interview on 09/15/10 at 3:57 PM with CNA #1, revealed he had been working at the facility approximately one month when the incident with Resident #3 occurred. The CNA stated Resident #3 was "a little dirty" when he and CNA #2 were trying to administer incontinent care about midnight 07/23/10. The resident tried to reach back to scratch, while he and CNA #2 were providing incontinent care. He told the resident to stop as the resident might have gotten "shit" on him/her. He grabbed the resident's wrist and placed the resident on his/her belly as a "first reaction." He grabbed the resident's wrist again when the resident's gown was changed. Both times he grabbed the resident's wrists, the resident complained that he was hurting his/her wrists. However, CNA #1 stated, " I do not think I	F 225		

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F 225	Continued From page 5 was hurting the resident that much, because there wasn't any bruising or broken bones found." He stated LPN #1 was aware of the incident but also did not feel he had hurt the resident. LPN #1 allowed him to continue working the same hall, with Resident #3 until about 4:00 AM when the Administrator called and told him that he was suspended and to clock out and go home. He was terminated on Tuesday, 07/27/10. An interview on 09/14/10 at 4:05 PM with the DON and a review of the facility reported complaint, revealed a mobile X-ray of Resident #3's right wrist on 07/28/10 at 10:25 AM failed to reveal a fracture, dislocation or soft tissue damage and indicated Osteoarthritis with no acute abnormalities. Review of the Time Card Detail dated 07/24/10, revealed CNA #1 clocked out of the facility at 4:19 AM and LPN #1 clocked out at 7:35 AM. The DON stated CNA #1 was taken off the floor as soon as the Administrator was made aware of the incident An interview on 09/15/10 at 1:15 PM with the Administrator, revealed LPN #1 was also terminated due to not reporting an incident immediately, allowing CNA #1 to provide direct care to residents nearly five hours after the incident, and falsification of documents regarding the notification of the physician and the family. Interviews were attempted with LPN #1 on 09/15/10 at 4:18 PM, and on 09/16/10 at 8:28 AM and at 2:00 PM, without success. 2. Resident #13 was admitted on 07/22/09 with diagnoses to include Anxiety and Senile Dementia. A review of the quarterly MDS, dated	F 225		

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F 225	Continued From page 6 07/15/10, revealed the resident was moderately impaired cognitively, totally dependent on the assist of two staff members for all care and was incontinent of bowel and bladder. Interviews on 09/15/10 at 2:07 PM and at 2:45 PM with CNA #2, revealed approximately two weeks prior to the above noted incident with Resident #3, CNA #1 and CNA #2 were working together on the night shift. Resident #13 was sitting at the nurses station, at approximately 1:00 AM. The resident was agitated and confused. The resident wanted a taxi and to go home and was attempting to get out of the chair unassisted. CNA #2 stated a call light sounded down the hallway and she asked CNA #1, who was sitting at the nurses station , to sit with Resident #13 while she answered the call light. When CNA #2 returned, she stated CNA #1 was taunting the resident and had Resident #13 so agitated, the resident was "red in the face." She overheard CNA #1 tell the resident that he/she could not leave the facility but he (CNA #1) could. CNA #2 requested CNA #1 to stop this and took the resident to the other end of the hallway to calm down. LPN #1 was at the nurses station and stated she wished CNA #1 would leave the resident alone. CNA #2 did not discuss the incident further with CNA #1 or the LPN and did not report the incident to the Administrator or DON. CNA #2 stated she was written up and suspended for two days over this incident. She stated she did not think much about it at the time because LPN #1 was there. She stated she felt if the LPN did not do anything about the situation, then maybe it did not need to be reported. LPN #1 was unavailable for comment. An interview on 09/15/10 at 2:07 PM with CNA #2	F 225		

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F 225	Continued From page 7 and a review of the facility's investigation report, dated 07/28/10, revealed the CNA had no recall of this incident. An interview with Resident #13 on 09/16/10 at 1:30 PM revealed the resident denied anyone ever hurting him/her, but also stated he/she "probably wouldn't remember it anyway." A review of the undated facility policy regarding Resident Abuse, revealed any alleged incidences of abuse, neglect or exploitation must be reported to the Administrator. Staff were also to report any signs of abuse, which may include but was not limited to bruises, sounds, or actions that may lead to mistreatment of a resident. The Administrator/Designee would then begin an investigation as to what occurred. Further review of the investigation category of the policy revealed if the incident involved suspected abuse, neglect or exploitation toward a resident, it shall be immediately reported to the employee's immediate supervisor and the Administrator, at which time an investigation would begin and the employee accused of alleged abuse would be suspended immediately.	F 225		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced	F 242	F242 Criteria #1 Director of Nursing interviewed resident #7 regarding his preference for bathing and shaving schedule. This was completed on 9/16/2010. It was also discussed with resident #7 his preference regarding personal hygiene items. Resident #7 preferred bed baths only, and would like them in daytime hours. He identified his preference for treatment of dry skin. Resident #7 was care planned For daily bed baths on day Shift, with hygiene care provided at that time. He will also be careplanned to use lotion or baby oil per his preference to treat dry skin. On 9/16/2010 Resident #7's Physician was contacted regarding Dry and flaky skin. He recommended Moisturizing two times a day. This Will also be documented on care plan for resident #7.	

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F 242	Continued From page 8 by: Based on observation, interview and record review, it was determined the facility failed to ensure one resident, (#7), in the selected sample of 10, was given the right to choose what time his/her bath and daily shaves were provided and was not asked if he/she was agreeable before a change was made to the time of these activities. Findings include: Observations on 09/14/10 at 10:30 AM, on 09/15/10 at 8:35 AM, 9:45 AM, and 11:30 AM, and on 09/16/10 at 9:50 AM, revealed Resident #7 was unkempt with white, scaly, flaky skin to his/her head and shoulder areas and was in need of a shave. An interview on 09/14/10 at 10:30 AM with Resident #7 and a family member, revealed the resident had a history of stroke and was unable to speak; however, he/she was able to communicate effectively using a wax-board with a plastic sheet and a stylet. The resident had concerns that the evening showers were "not too good." Resident #7 was admitted on 10/13/09 with diagnoses to include Quadriplegia from a Brain Stem Infarct, Previous Myocardial Infarction and Progressive Weakness. The quarterly Minimum Data Set (MDS) dated 07/19/10, revealed the resident's cognitive level was independent, with no short or long term memory deficits. He/she was totally dependent on the assistance of two staff members for care. The care plan for activities of daily living revealed the resident was able to manipulate the urinal, if it was left on the side of the wheelchair. The resident was able to feed him/herself with assistive devices and set-up	F 242	Criteria #2 Director of Nursing, Unit Coordinator, and Assistant Director of Nursing will interview current Nursing Facility Residents to determine preference for bathing/hygiene times of current residents. The preferential time will be documented by the Director of Nursing, Unit Coordinator, and Assistant Director of Nursing on the comprehensive care plan and CNA care plan. Criteria #3 On admission of a new resident they will be interviewed by the Unit Coordinator to determine any preferences for bathing and hygiene. The Unit Coordinator will document these on initial admission care plan and CNA care plan. Nursing staff will be provided inservice/training By the Unit Coordinator that if a preference should Change they must notify Unit Coordinator to ensure That the comprehensive care plan and CNA care plan are changed to reflect preferences. Nursing Staff will also be inserviced by the Unit Coordinator to ensure that they are checking CNA care plans on a daily basis to ensure that we are meeting preference of residents.	

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F 242	Continued From page 9 of the tray on the lap top table. A review of the CNA Care Plan Record for Sept 2010, revealed the resident was to receive total bed baths in the afternoon on Monday, Wednesday and Friday. No mention of a shave or the resident's preferences were noted. An interview with CNAs #3 and #4 and LPN #2 on 09/16/10 at 10:30 AM, revealed the CNAs were not aware of the resident's bath and skin care needs as the resident was bathed on the evening shift and the LPN was newly hired. An interview on 09/16/10 at 11:25 AM with the DON, who was new to this position, revealed she was not aware the resident had been changed from day shift to the evening shift for bathing. The DON then interviewed the resident regarding his/her shift preference for bathing and shaving. The resident revealed a preference for day shift.	F 242	Criteria #4 One time a month CNA care plans will be reviewed By the Unit Coordinator to ensure preferences are noted on the CNA care plan and comprehensive care plan. One time a month for three months the Unit Coordinator will interview residents to ensure that preferences have not changed. Unit Coordinator will document any changes on comprehensive/CNA care plans. After the initial three months this process will be completed every quarter by the Unit Coordinator. Criteria #5 October 20, 2010	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185410	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER'S BEND RETIREMENT COMMUNITY	300 BEECH ST. KUTTAWA, KY 42055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 09/14/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.